

USAID | Nepal

Suaahara (Good Nutrition)

Semi-annual Progress Report:
September 1, 2011 through January 31, 2012

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Table of Contents

| | |
|---|----|
| Acronyms | |
| 1. Background | 1 |
| 2. Key Activities during Reporting Period | 2 |
| 2.1 Project Management: Start Up Activities..... | 2 |
| 2.2 Deliverables | 4 |
| 2.3 Program Implementation Activities | 4 |
| Gender Equity and Social Inclusion | 4 |
| Social and Behavior Change Communication | 5 |
| IR 1: Household health and nutrition behaviors are improved | 6 |
| IR 2: Increased use of quality health and nutrition services by women and children | 6 |
| IR 3: Women and their families increase their consumption of diverse and nutritious foods | 7 |
| IR 4: Coordination on nutrition between government and other actors is strengthened | 8 |
| Design, Monitoring and Evaluation | 8 |
| 2.4 Justification for incomplete activities as per work plan | 9 |
| 3. Anticipated future problems, delays or conditions or constraints that may adversely affect program implementation | 11 |
| 4. Security Issues | 11 |
| 5. Financial Status Summary | 11 |
| Annexes | |
| I. Suaahara Results Framework | 12 |
| II. Formative Research Concept Note / Protocol | 13 |

Acronyms

| | |
|---------|---|
| BCC | Behavior Change Communication |
| CB-GMP | Community-based Growth Monitoring and Promotion |
| CB-IMCI | Community-based Integrated Management of Childhood Illnesses |
| CERF | Central Emergency Response Fund |
| CHD | Child Health Division |
| CLTS | Community-led Total Sanitation |
| CMAM | Community-based Management of Acute Malnutrition |
| DADO | District Agriculture Development Office |
| DDC | District Development Committee |
| DEO | District Education Office |
| DFID | Department for International Development |
| DHO | District Health Office |
| DLSO | District Livestock Service Office |
| DOA | Department of Agriculture |
| DOHS | Department of Health Services |
| DPHO | District Public Health Office |
| DRR | Disaster Risk Reduction |
| DWDO | District Women's Development Office |
| EDP | External Development Partner |
| EHA | Essential Hygiene Actions |
| ENA | Essential Nutrition Actions |
| ENA+ | Essential Nutrition Actions + Agriculture, Hygiene, FP, MNCH, smoking |
| EOI | Expression of Interest |
| FATVAH | Frequency, Amount, Texture, Variety, Active Feeding and Hygiene |
| FCHV | Female Community Health Volunteer |
| FHD | Family Health Division |
| FP | Family Planning |
| GESI | Gender Equality and Social Inclusion |
| GMP | Growth Monitoring and Promotion |
| GON | Government of Nepal |
| HA | Health Assistant |
| HF | Health Facility |
| HFP | Homestead Food Production |
| HKI | Helen Keller International |
| HTSP | Healthy Timing and Spacing of Pregnancy |
| IFPRI | International Food Policy and Research Institute |
| IMCI | Integrated Management of Childhood Illnesses |
| IYCF | Infant and Young Child Feeding |
| IYCN | Infant and Young Child Nutrition |
| JHU/CCP | Johns Hopkins Bloomberg School of Public Health Center for Communication Programs |
| LAM | Lactational Amenorrhea |
| MI | Micronutrient Initiative |
| MNCH | Maternal, Newborn and Child Health |
| MNP | Micronutrient Powder |
| MoAC | Ministry of Agriculture and Cooperatives |
| MoES | Ministry of Education and Sports |
| MoF | Ministry of Finance |

| | |
|---------|---|
| MHP | Ministry of Health and Population |
| MoLD | Ministry of Local Development |
| MOU | Memorandum of Understanding |
| MTOT | Master Training of Trainers |
| MUAC | Mid-Upper Arm Circumference |
| MWCSW | Ministry of Women, Children and Social Welfare |
| N-CRSP | Nutrition-Collaborative Research Support Project |
| NEWAH | Nepal Water for Health |
| NFHP II | Nepal Family Health Program II |
| NHEICC | National Health Education Information Division and Communication Center |
| NHSP | National Health Sector Program |
| NNAP | National Nutrition Action Plan |
| NNCC | National Nutrition Coordination Committee |
| NNP | Nepal Nutrition Group |
| NPC | National Planning Commission |
| NPCS | Nutrition Promotion and Consultancy Service |
| NRC | Nutrition Rehabilitation Center |
| NTAG | Nepali Technical Assistance Group |
| NUTEC | Nutrition Technical Committee |
| ORC | Outreach Clinic |
| PAL | Pre-Award Letter of Authorization |
| PNC | Postnatal Care |
| PPP | Public Private Partnership |
| RFA | Request for Applications |
| RFP | Request for Proposals |
| RHTC | Regional Health Training Center |
| RIDA | Research Inputs and Development Actions |
| RUTF | Ready-to-Use Therapeutic Food |
| SAM | Severe Acute Malnutrition |
| SBCC | Social and Behavior Change Communication |
| SCI | Save the Children International |
| TAG | Technical Advisory Group |
| VA | Vitamin A |
| VDC | Village Development Committee |
| VMF | Village Model Farm |
| WASH | Water, Sanitation and Hygiene |
| WFP | World Food Program |

1. Background

*Suaahara*¹ is a five-year USAID-funded project (August 2011-August 2016) using a comprehensive, household-based approach to improve access to, and consumption of, nutritious foods in areas with very poor nutrition indicators. Its main objective is to improve the nutritional status of pregnant and lactating women and children under two years of age directly addressing the vulnerable points of development which result in stunting. *Suaahara*'s strategy evolved from the *Nepal Nutrition Assessment and Gap Analysis* and the government of Nepal's second national Health Sector Program (2010-2015). The program focuses on improving nutrition; maternal, newborn, and child health (MNCH) services; family planning services; water, sanitation and hygiene; and home-based gardening. *Suaahara*'s cross-cutting themes include social and behavior change communication (SBCC), gender equality and social inclusion (GESI), capacity building, and learning through continuous monitoring and evaluation.

Suaahara partners include Save the Children (prime), Helen Keller International, Jhpiego, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, Nepali Technical Assistance Group, Nutrition Promotion and Consultancy Service and Nepal Water for Health.

One of the distinguishing elements of *Suaahara* is the integration of various sectors—including agriculture—to achieve improved nutrition for vulnerable populations. In nine districts, *Suaahara* is implementing intensive homestead food production interventions which may expand to other districts, as appropriate. In other districts *Suaahara* promotes key hygiene behaviors—and in particular, handwashing. All *Suaahara* interventions are district-wide activities, implemented through village development committees (VDCs).

The SBCC component for *Suaahara* aims to increase demand for various services provided through the health system (e.g., family planning, micronutrients, de-worming) and to improve household behaviors related to infant and young child nutrition (IYCN), family planning (FP) and hygiene practices. The SBCC strategy for *Suaahara* will use a mix of approaches and contacts to ensure a continuum of care. This will include contacts at critical points through health facilities, via home visits done by female community health volunteers (FCHVs) and broader media campaigns. *Suaahara* also works actively to improve the quality and coverage of services provided through the health system, including activities to improve counseling services at sick child visits, facility capacity to detect and treat severe acute malnutrition (SAM), and strengthening skills for lactation management by FCHVs and health facility staff.

The agricultural interventions provided by *Suaahara* will include a set of homestead food production (HFP) interventions based on HKI's extensive experience in Nepal. The package of HFP interventions includes village model farms, community brooding centers for poultry, homestead gardens and backyard poultry. Inputs for these interventions include training, capacity building, modeling, and supplies such as vaccines for poultry, seeds and saplings, among others. It is quite likely that *Suaahara* will work with the government and local

¹ *Suaahara* (Good Nutrition) stands for *Suddha Santulit Aahar Hamro Jeevan ko Raksha ko Baliyo Aadhar* "A good balanced diet is the strong foundation protecting our lives."

NGOs to introduce animal source foods in all or almost all *Suaahara* districts given that children's consumption of animal source foods is about 5% nationally.

This mix of supply-side service strengthening and the demand creation for improved health and nutrition services as well as the additional HFP and WASH interventions are intended to ensure that *Suaahara* communities get a full set of multisectoral interventions to improve food availability, access and utilization, and to enhance overall health, improve healthy timing and spacing of births, and thus lead to healthier lives for women and children.

This first semi-annual progress report will review the activities noted in the *Suaahara* work plan for this period and follow the organization of the workplan beginning with Administration and Personnel and proceeding with the programmatic strategy which is based on the *Results Framework* for *Suaahara* which is attached in Annex I.

2. Key Activities during Reporting Period

2.1 Project Management: Start-Up Activities

- **Sub-agreements with partners:**
Pre-award letters of authorization (PALs), valid through February 29, 2012, were issued by the end of September to each of the *Suaahara* partners.
- **Hiring of personnel:**
Twenty-two staff based in Kathmandu were engaged during this period. Recruitment is ongoing for the following Kathmandu-based positions: Internal Auditor, Senior Health Systems Coordinator, HFP/Water Access Coordinator, Senior M&E and Database Coordinator, Finance & Administration Assistant JHU/CCP, and Receptionist/Secretary.
- **Cluster offices:**
Existing Save the Children offices will be used in the Far Western (Dhangadi), Central (Kathmandu) and Eastern (Biratnagar) regions. Until *Suaahara* staff members are hired, the Regional Program Managers in those offices will be overseeing *Suaahara* activities.

A new office has been leased and made operational in Pokhara to serve the eight districts in the Western region with a sub-office located in Butwal to support Rupandehi and Nawalparasi. In addition to the existing Save the Children Regional Program Manager, the following *Suaahara* staff were engaged during this reporting period: Finance and Administration Coordinator, driver and one support staff.

- ***Suaahara* partner meetings:**
Team building and strategic planning meetings were held with *Suaahara* partners on September 8th, September 26th & 27th and November 7th-11th. A three-day Finance workshop was held January 9th-11th with a focus on USAID Rules and Regulations.
- **Technical Advisory Group**
There have been discussions since October regarding the nature and purpose of this group. The ongoing need for external advice is evident. Given that it is the same pool of (extremely busy) people who would be called on, we decided not to have a formal group meeting regularly but to have ad hoc meetings based on issues at hand, inviting only those persons with related expertise/experience, detailing the issue to be considered well in advance to ensure efficient use of time.

▪ **Selection of local NGO partners**

A framework for the evaluation of potential NGO partners was developed. A request for expressions of interest (EOI) was advertised. Over 50 responses were received. Selection will be made during March.

▪ **Collaboration with government and other stakeholders:**

- **Department of Health Services** - Consultation meeting with key members - December 21st.
- **N-CRSP** – *Suaahara* has linked closely with Nutrition-CRSP since the start of the project and is coordinating with them and with IFPRI closely to maximize the programmatic usefulness of the *Suaahara* baseline.
- **NNP**: Participation on NNP
- **EDP**: Presentation of *Suaahara* to EDP on November 23rd; collaboration with World Bank on baseline; exchange of information with World Bank about Rapid Results strategy; collaboration with UNICEF on revision of nutrition materials and promoting micronutrients, CMAM and IYCF in overlapping districts; discussions with WFP and EC re: potential collaboration.
- During this reporting period, the *Suaahara* nutrition team participated in different nutrition-related dissemination forums such as that for zinc formative research and evaluation of CMAM pilot programs organized by MI and UNICEF respectively. These meetings helped program implementation planning as they highlighted areas that need further attention such as low zinc compliance for diarrhea treatment. Similarly, the team also participated in the National Reproductive Health Program annual review meeting that was organized by the Family Health Division (FHD). At this meeting, the *Suaahara* team shared how the program could contribute to the national nutrition and reproductive health programs.
- Shared *Suaahara* program activities at the Hygiene and Sanitation Committee meeting and sought feedback.
- Started collecting secondary data on hygiene and sanitation in *Suaahara* early implementation districts (Bajhang, Bajura, Parbat, Syangjha, Sindupalchowk, Baglung, Nawalparasi and Rupandehi).
- Consulted the Department of Agriculture to develop the homestead food production (HFP) training manual. It was noted that there is no national level HFP training manual.

▪ **Key Meetings and Technical Working Groups:**

- *Suaahara* supported the CHD Nutrition Section to develop fiscal year 2069/70 (2012-2013) annual workplan jointly with external development partners (EDP). The planning meeting was held on 29 January 2012 and the participants were CHD, USAID, UNICEF, Save the Children, *Suaahara* and HKI. During this planning meeting, participants mapped national nutrition priorities and shared EDP activities with budget. All EDPs, including *Suaahara*, included planned activities with budgets in the CHD work plan.
- *Suaahara* Nutrition Program Manager participated in the Emergency Nutrition Cluster meeting that was organized by UNICEF. The objective of the meeting was to identify the Nutrition Cluster priority for Central Emergency Response Fund (CERF) application for 2012 and prepare the Nutrition Cluster planning outline to develop the workplan for 2012. From this meeting, *Suaahara* was included as a member of the Nutrition Cluster.

- Various program staff contributed to sub-committees of NUTEC including those related to IMCI, IYCF, GMP, maternal nutrition and anemia.
- **Other:**
 - Communications strategy developed
 - Agricultural inputs waiver request submitted

2.2 Deliverables

Following are the key deliverables *Suaahara* submitted during the reporting period:

- **Performance Monitoring and Evaluation Plan**

Suaahara submitted a Performance Monitoring and Evaluation Plan (PMP) on October 27, 2011. It was further revised and re-submitted November 18, 2011, December 8, 2011 and January 3, 2012.

This was developed based on USAID guidelines and contains items such as the *Suaahara* Results Framework, monitoring and evaluation plan including baseline, data quality assurance and structure and systems for monitoring and evaluation. The PMP also includes a matrix which details indicators for different levels of results with corresponding data source, methodology, frequency and data quality assurance plans. Various levels of indicators are identified (output, outcome and impact) for different sectors of the PMP, along with the USAID Operational Program indicators.

- **Workplan**

A draft life of project workplan for all sectors and cross cutting areas (GESI, SBCC and M&E) was submitted along with the PMP. Two revisions of the workplan were made from suggestions from USAID. A detailed year one workplan with budget by category was also developed. The workplan was approved January 6, 2012.

- **SF 425s**

Two SF 425s were submitted during this reporting period: on October 30th for the period 8/30/2011 through 9/30/2011 and on January 30th for the period of 8/30/2011 through 12/31/2011.

2.3 Program Implementation Activities

Gender Equality and Social Inclusion

- Identify most vulnerable social groups in every district affecting *Suaahara* outcomes
- Engage vulnerable social groups through FCHVs and poshan aamas, supported by the local NGOs and existing local community structures.
- Development of GESI strategy for *Suaahara*
- Coordinate with GESI network, NHSSP, MOHP, FHD and others working in health system.
- Develop strategies for working with and involving men/mother-in-laws

As a cross cutting theme, the overarching focus of this reporting period has been to orient *Suaahara* staff and partners to basic GESI concepts and how these might be integrated into *Suaahara's* activities.

The following activities specifically contributed to this objective:

- At the September 26th and 27th meeting GESI activities were identified and indicators that reflect GESI were developed and incorporated into the *Performance Monitoring and Implementation Plan (PMP)*.
- A session during the strategic planning workshop November 7th-11th was devoted to GESI. This focused on critical aspects of GESI and possible areas of integration. Key GESI considerations were identified and discussed as related to training, social and behavior change communication, the baseline survey and formative research.
- *Baseline Survey*: Aspects of gender equity and social inclusion such as the socio-economic status of women, women's decision making, time allocation, work load, food distribution, group participation of the marginalized, etc. were discussed and conceptualized for incorporation in the baseline survey.
- *Formative Research*: Similarly, structural and underlying barriers, gendered norms, beliefs and behaviors that promote gender inequity and exclusion affecting the nutrition of women and children were incorporated into the design of formative research. It is expected that the formative research and the baseline survey will identify gaps to develop GESI strategies further.
- *Training*: A rigorous exercise has been done to incorporate GESI issues in the contents of master trainers of training and key messages to be delivered down to the community level.
- *Review of existing SBCC materials*: The existing available SBCC materials relating to IYCF and hygiene and sanitation have also been reviewed from a GESI perspective to reflect whether they are gender and inclusion sensitive and transformative in nature. The identified gaps will be addressed to improve the materials from a GESI perspective and for use in the *Suaahara* program.
- *Checklists*: An initial checklist has been developed to help design, monitor/evaluate and improve upon programs so that all *Suaahara* activities are gender sensitive and socially inclusive. In the course of program implementation it will be updated based on identified issues and gaps.
- *Staff orientation*: A one day orientation for 17 *Suaahara* staff members was organized on January 27th to develop a basic understanding of gender and social inclusion.

Social and Behavior Change Communication

- Develop and conduct SBCC formative research (e.g., perceptual mapping)
- Align with formative research data and government policies/strategies; Review of existing SBCC strategies adapted for different health & nutrition programs by government and development partners; Work closely with MoHP's recently initiated MIYCF communication strategy working group
- Develop replicable "Swasthaya Privar" healthy community models for social mobilization at the community level
- Develop plans for participatory community and school activities
- During the reporting period, a concept note and research protocol were shared for extensive review and finalized. A Request for Proposal (RFP) was published in early January 2012 and 11 proposals were received from research organizations. A research firm was selected in February. Dr. Rajiv Rimal will

come in March to work with RIDA (Research Inputs and Development Action) and begin the research.

- In preparation for the development of a Communication, Advocacy and Social Mobilization strategy for *Suaahara*, a desk review of existing research and SBCC strategies was begun during this reporting period. The desk review will 1) identify nutrition-related behaviors, gaps, barriers and influencing factors for behavior change and 2) review existing strategies such as the national nutrition strategy, IYCF, and the maternal and child health communication strategy to ensure strategic harmonization.

IR 1: Household Health and Nutrition Behaviors are Improved

1.1 Households adopt essential nutrition actions (ENA) including infant and young child feeding (IYCF)

- In coordination with SBCC and capacity building teams, reviewed ten ENA and other related global and national protocols and materials to identify strengths and gaps with a focus on harmonizing ENA+ messages, particularly infant and young child feeding messages. After review, contributed to master trainer of trainers (MTotT) training outline and developed key ENA+ messages, particularly related to breast feeding, complementary feeding and feeding of the sick child.
- Working with the entire program team, the Deputy Chief of Party, Programs and the Program Implementation Advisor developed a tool to help determine the most appropriate interventions for improving ENA/EHA behaviors as well as reproductive/family planning and other nutrition-sensitive behaviors.
- Worked with Maryanne Stone-Jimenez, who will lead a Master Training of Trainers, to plan the MTotT which will be held late February/early March.

1.2 Households adopt essential hygiene actions (EHA)

- Contributed to MTotT training outline and developed key ENA+ messages, particularly related to hygiene and sanitation messages. Conducted preparatory work for development of EHA SBCC materials in coordination with the SBCC team and the Hygiene and Sanitation Committee.

IR2: Increased Use of Quality Health and Nutrition Services by Women and Children

2.1 Improved access to high quality, facility-based services

- Began strategic planning discussions for FP/MNCH/nutrition integration within *Suaahara* from community to facility
- Participated and contributed to the Annual National Reproductive Health Review and Planning workshop held 26-28 December 2011
- Incorporated FP/MNCH-related issues in the formative research terms of reference and community assessment tools.

2.2 Improved facility-based integrated management of childhood illnesses (IMCI) activities

- Nutrition Program Manager attended the three-day IMCI protocols review workshop organized by the Child Health Division (CHD). In this workshop the Nutrition Program Manager contributed to revision of the nutrition component of

the protocols. It was noted that the protocols did not address nutrition sufficiently, thus the treatment chart book related to nutrition problems, nutrition-related counseling and the complementary feeding schedule were updated. The protocols are currently under revision.

2.3 Improved growth monitoring programming (GMP): facility and community

This output has been postponed to begin in year two.

2.4 Improved treatment of severe acute malnutrition and possibly community-based treatment of acute malnutrition

Suaahara and UNICEF began a process for formalized collaboration on the revision of nutrition materials and promoting micronutrients, CMAM and IYCF in overlapping districts (as noted on page 3 **Collaboration with government and other stakeholders**). A Memorandum of Understanding is being developed with review activities expected to begin in March 2012 and other activities in the 3rd and 4th quarters of 2012.

2.5 Facility-based and outreach family planning services provide effective counseling on healthy timing and spacing of pregnancy (HTSP) as important for good health and nutrition

- Began strategic planning for HTSP integration within *Suaahara* from community to facility
- Visited three program districts for rapid initial assessment to explore FP/MNCH-related issues in December

IR3: Women & their families increase their consumption of diverse and nutritious foods

3.1 Increased access to locally-produced nutrient-dense and fortified foods

- Developed agenda for homestead food production (HFP) MToT at national level. Trainers trained at the MToT will then train the district-level trainers, who in turn will train the village model farm (VMF) owners.
- Collected and reviewed national and global materials, including IEC materials, to identify gaps and strengths to develop food-based strategy.

3.3. Increased community resiliency to potential nutrition shocks through community-based initiatives

- Nutrition team is currently reviewing global and national materials on nutritional resiliency during emergencies such as the National Strategy for Disaster Risk Management in Nepal; IASC Nutrition Cluster A Toolkit for Addressing Nutrition in Emergency Situation; USAID Integrating Relief and Development to Accelerate Reductions in Food Insecurity in Shock-Prone Areas and PowerPoint slides shared by Dr. Mary Lung'aho of CARE on infant feeding in emergencies.

IR4: Coordination on nutrition between government and other actors is strengthened

4.1 A national mechanism in place that allows regular coordination and information sharing among government and other entities with responsibilities for achieving MDG 1 and reducing the level of under-nutrition in Nepal

JHUCCP's K4H (Knowledge for Health) staff developed a knowledge sharing website for *Suaahara* to help *Suaahara* partners work synergistically by providing one virtual space to share and comment on research, resources, activities, successes, and other information related to the project. A portion of the website will be used internally by *Suaahara* staff and a portion will be for the broader global development community and contains many resources donors, governments, EDPs and NGOs can use to improve integrated nutrition programming.

The website address is: <http://www.k4health.org/toolkits/suaahara-nutrition-project>

4.2 Regional and District Mechanism in Place

Please refer to pages 2 and 3: ***Collaboration with government and other stakeholders*** for activities in support of this IR output.

Design, Monitoring and Evaluation

■ Baseline

An initial two day meeting (December 1-2) was held with IFPRI, who will lead the baseline. The main agenda of the meeting was to discuss the *Suaahara* baseline design and possible areas of collaboration. Participants were representatives from USAID, N-CRSP, World Bank, IFPRI and *Suaahara*. This meeting was followed by email communications and calls with IFPRI. As a result, the design for the baseline is finalized, the RFP for the Nepali survey firm has been issued and the contract with IFPRI is underway.

The baseline will include about eight *Suaahara* districts with equal numbers of similar non-*Suaahara* districts as the comparison group with a sample size of 2000 households in each group. IFPRI's role will be to design the baseline, questionnaires and tools, train the baseline team, data analysis, report writing and dissemination. A Request for Proposals (RFP) for Nepali survey firms was issued with a deadline of February 17. The role of the Nepali survey firm is to pretest the questionnaires, get ethical approval from the Nepal Health Research Council (NHRC), train enumerators and collect data ensuring data quality, including the collection of anthropometric data plus hemoglobin. *Suaahara* will provide logistics and management support to the baseline. It is expected that the data collection will begin in April and the baseline report will be in place by July/August. There is currently ongoing discussion with Tufts University and the N-CRSP initiative to determine how the baseline and end line might be augmented by small cohort studies that track a sub-sample of children over time and by operations research.

▪ **Formative Research**

The primary objective of formative research is to gain an in-depth understanding about the primary determinants of key behaviors of interest to *Suaahara*. These behaviors include breastfeeding, complementary feeding, food preparation, sanitation & hand washing, and other behaviors related to infant and child care. The formative research is led by the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU/CCP). In response to the RFP issued during this reporting period, a total of 11 interested Nepali research firms submitted proposals. As noted previously, RIDA was given the award. It is expected that the field work will begin in March and the final report will be in place by late May. (See Annex II for further detail.)

▪ **Process indicators**

As part of developing the detailed M&E plan for the project, the team has drafted process indicators for all sectors, including cross cutting themes. This is developed based on the *Suaahara Results Framework*, and identifies process/output indicators to be monitored at the district, cluster and central level. This will enable the team to routinely monitor the progress made on different IRs and outputs. Development of routine data collection tools is underway.

▪ **Orientation on TraiNet**

Two staff from *Suaahara*, (M&E Manager and IT Coordinator) received an orientation on TraiNet at USAID on January 20th and have received log- in credentials. Plans are underway to orient the *Suaahara* team on information that is required on capacity building activities to enter into the TraiNet system.

2.4 Justification for incomplete activities as per work plan:

| Incomplete work plan activities | Justification |
|--|--|
| Start Up Hold full <i>Suaahara</i> team orientation to strategy and activities | Recruitment not expected to be complete until mid-April |
| <i>Suaahara</i> launch (Dec. 21-25) | Tied to Rajiv Shah's visit which was cancelled. |
| BCC Develop unifying behavior change concept to integrate across program (i.e., life cycle approach) | In process—not finalized |
| Align with formative research data and government policies /strategies | This activity postponed due to the fact that formative research has not yet been completed |
| Develop plans for participatory community and school activities | Due to the delay in MHP approval, district level activities will not officially begin until March. |
| IR Output 1.1 Create an enabling environment (household, community, health system) for sustained positive health and nutrition behavior change | Due to the delay in MHP approval, district level activities will not officially begin until March. |
| IR Output. 1.2 Work with government departments, WASH clusters, D-WASH CC, V-WASH CC, community | Due to the delay in MHP approval, district level activities will not officially begin until |

| Incomplete work plan activities | Justification |
|--|--|
| groups & local NGOs to advocate for improved water &/or sanitation and hygiene services | March. |
| CLTS Training | Due to the above, staff were not yet on board during the reporting period. |
| IR Output 2.2 Strengthen nutrition component of IMCI in competency-based refresher training package & job aids | In process but not completed |
| Strengthen IMCI facility services using a quality improvement process and standards | Due to delay in hiring staff and in receiving government authorization to enter districts |
| IR Output 2.3 Map current GMP coverage in target districts and prepare draft plan for optimal points of linkage for CB-GMP to other health service (EPI, ANC, VA, IMCI, CMAM) – scale up with phasing plan | Nutrition team focused on preparations for ENA+ training in the first six months; consequently they postponed this activity to the next six month period. |
| Review current GMP content protocols, training and counselling materials (Nepal and global) for HA, MCHW, VHW, FCHVs/ poshan aamas and identify gaps | Nutrition team focused on preparations for ENA+ training in the first six months and postponed this activity to the next six months |
| Work with MoHP to secure regular basic supplies for CB-GMP to facilities and outreach clinics (ORCs) quarterly planning and review | Nutrition team focused on preparations for ENA+ training in the first six months and postponed this activity to the next six months |
| IR Output 2.4 Review nutrition rehabilitation materials and procedures in coordination with UNICEF and MoHP to ensure better integration of IMCI, ENA+, IYCF and SAM | Discussions mapping a plan for this activity began during this reporting period. A Memorandum of Understanding between Suaahara and UNICEF is now being finalized. |
| IR Output 2.5 Conduct annual FP compliance orientation/certification for all Suaahara & NGO partner staff, poshan aamas, health care providers, FCHVs | This is in process for the third quarter of year one. |
| Develop training materials and job aids to strengthen facility-based and community health services on HTSP/FP, FP and its potential impact on MNCH and nutrition | This process is beginning in the third quarter of year one. |
| Strengthen quality of HTSP and FP services using a quality improvement process and standards in HF, ORCs and EPI. | This hasn't started due to the delay in getting approvals to enter the districts. |
| Incorporate messages targeting health workers and clients that link nutrition, HTSP and MNCH into existing SBCC materials and mass media communications | This activity will be informed by the qualitative research which will be occurring in March and April, 2012. |
| Promote exclusive breastfeeding, LAM and transition to other FP methods within ENA+ at the community/household level and within facilities. | This activity will be initiated with the staffing of the district and cluster offices. |
| IR Output 3.3 Support BCC/IEC for expanded use of low-cost household level food preservation and storage techniques. | This activity will begin once districts are fully staffed. This has been delayed because of the delay in getting DHS official authorization. |

| Incomplete work plan activities | Justification |
|---|---|
| Design, Monitoring & Evaluation Collaboration with WFP's VAM unit to collect food security and nutrition indicators | Initial discussion made. Delayed because of different target groups of <i>Suaahara</i> and VAM. Plans to further coordinate with VAM. |

3. Anticipated future problems, delays or conditions or constraints that may adversely affect program implementation

None

4. Security Issues

None

5. Financial Status Summary

The preliminary expenditure report for this reporting period (as of January 31, 2012) is as follows:

Budget Elements

| | |
|--|----------------|
| Personnel/Fringe Benefits and Allowances | 138,726 |
| Travel and Per Diem/Supplies and Equipment | 14,820 |
| Contractual/Other Direct Costs | 7,008 |
| Sub agreements/Program Costs | 222,381 |
| Indirect Charges | 44,852 |
| Total USAID Contribution | 427,788 |
| Cost Share | 82,675 |
| Total Program Expenditures | 510,463 |

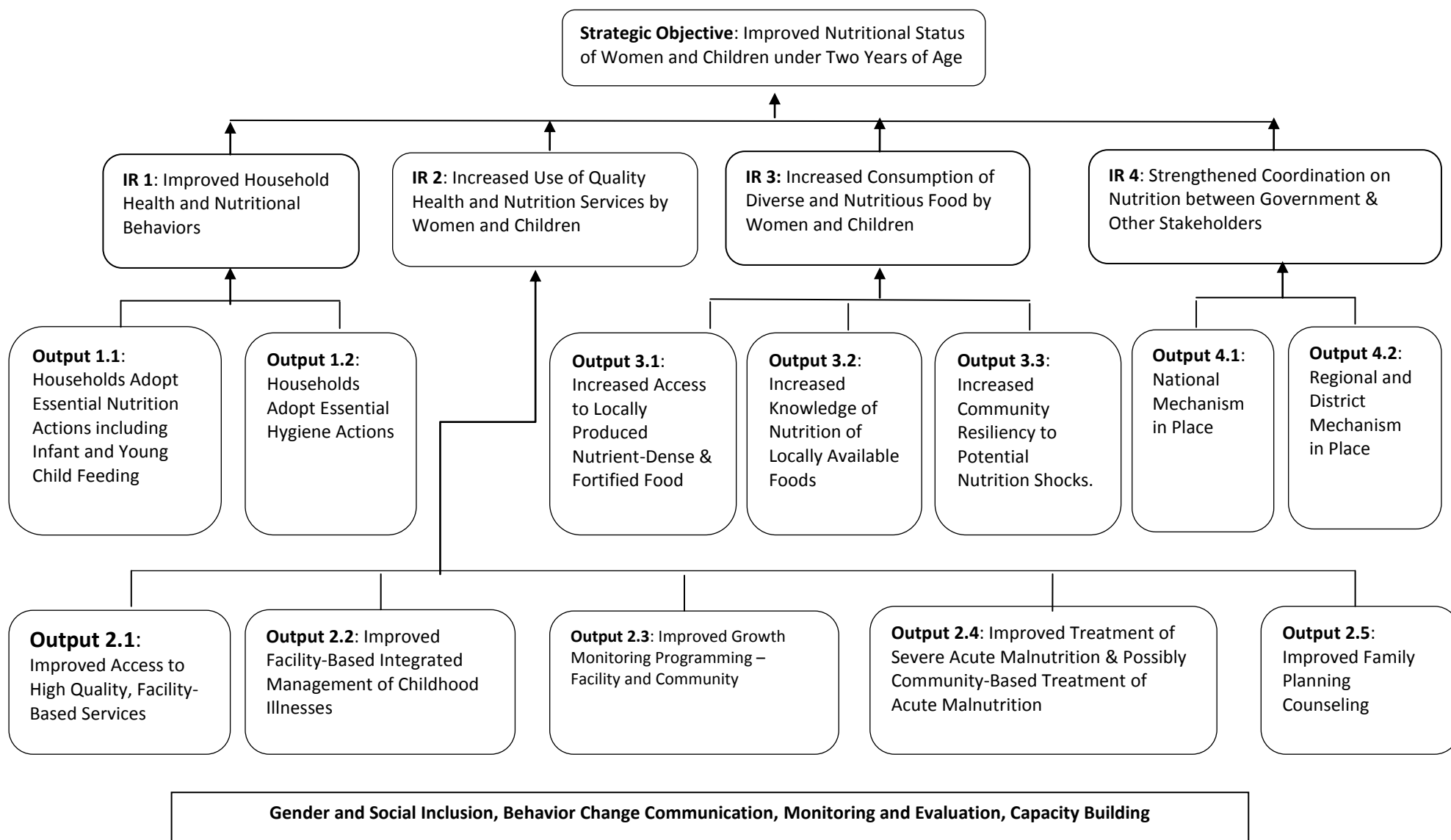
We experienced some delays in procurement during this reporting period, particularly in procurement of vehicles and hiring of consultants for baseline survey and formative research, due to which the total expenditures have been lower than anticipated. We expect these big ticket items to be procured and hit the books by early April, 2012.

Additionally, trainings planned to have happened during this period were postponed until March due to the delay in getting official Department of Health Services authorization to work at a district level. With this approval now in hand, the next months will involve more than a doubling of staff and intensive training at a national and district level. Our expectation is that the resources projected for year one will be used.

The initial obligation of \$2,000,000 was increased through Modification #1 on December 6, 2011 to \$9,812,031 for the first year of the program.

Annex I

Results Framework



Annex II

Suaahara Project Formative Research Concept Note /Protocol

*Seeking a Household-Focused Understanding of Behavioral and Cultural Practices to Improve
Infant and Child Health and Nutrition Outcomes in Nepal*

Objective

The primary objective of this formative research is to gain an in-depth understanding about the primary determinants of key behaviors of interest to the SUA AHARA program. These behaviors include breastfeeding, complementary feeding, food preparation, sanitation and hygiene and other behaviors related to infant and child care. The underlying assumption behind this effort is that such an understanding can assist the project in developing, implementing, and evaluating a multilevel intervention that promotes the health and well-being of young children, infants, and their families.

Background

Seckel and her colleagues² recently conducted a formative research on infant and young child feeding practices in rural Nepal,³ and they identified six important factors that need to be considered by program planners and incorporated into intervention design. These factors [order rearranged for clarity] are (a) demands and constraints faced by mothers, (b) feeding practices, including complimentary feeding and breastfeeding, (c) household-level factors that impinge on family decision-making, (d) sources & availability of foods, (e) the role of health workers, including FCHVs, and (f) larger cultural & contextual factors, including gender roles. The formative research for SUA AHARA builds on this framework.

The six factors noted by Seckel et al. refer to actions or processes either inside the home (for example: constraints mothers face, what they feed, and how household-level decisions are made) or outside the home (what foods are available, which outsiders interact with the family, and the larger cultural context in which the family exists). This framework suggests that the household – i.e., the family – be conceptualized as a key unit of emphasis. The household is the venue where important decisions are made with regard to infant and young child feeding practices, and it is the unit with which health workers interact to bring about change. These interactions, in turn, occur within the larger socio-cultural context in which traditions, norms, and gender roles are practiced.

One of the key implications of conceptualizing the household as the unit of intervention is that it focuses our efforts not on individuals per se (e.g., the mother, the child, the father), but rather on the *relationships* that exist within the home. It forces us to think broadly about external forces that impinge on the family (e.g., cultural norms, social structures, community resources), internal dynamics among family members (relationships between

² Seckel, L. et al. (2011). Factors that constrain or prevent optimal infant and young child feeding practices in rural Nepal: Findings from a formative research study in three districts. *Nepal Family Health Program II*.

³

couples, between parents and their infants, between the couple and their in-laws), and the interactions between them.

For the purposes of the proposed formative evaluation, we will draw extensively from studies that have been conducted recently to understand nutrition practices in various parts of Nepal and also from study conducted by World Bank on Nutrition and Gender in South Asia. In accordance with the formulation described above, we have organized our research questions in terms of dynamics that take place inside or outside the home (please see Annex A for examples).

Research Methods

In order to gain an in-depth understanding about internal and external dynamics surrounding the family, we will adopt four research procedures:

- Focus group discussions
- In-depth interviews
- Perceptual mapping techniques
- Participant observations

Research Sites

Given the extensive cultural, linguistic, and geographical diversity that exists within Nepal, it is virtually impossible to conduct this formative research in such a way that its findings would generalize to the entire country. Rather, we have sought to gain a workable knowledge from findings that emerge from five different regions in the country. In these regions, we will prioritize remote areas, ones that are likely to have remained underserved by other interventions. In each site, we will make further attempts to reach out to populations that remain underserved, stigmatized, or otherwise neglected. The proposed work will be done in five sites:

- Far western region: Bajhang
- Western region: Manang
- Terai region: Rupandehi
- Central region: Rasuwa
- Eastern region: Taplejung

Within each district, particular locations for data collection will be selected through discussions with partners on the ground, and with consideration given to the following factors:

- selection of areas that will result in maximum representation of the diversity within the district
- inclusion of areas within the district that tend to be marginalized because of their location (that makes them inaccessible) or because of members of certain ethnic groups or castes who live there

Process and Procedure

We will publish a request for proposals (RFP) from research agencies in Nepal to carry out the proposed work. The selected agency will be asked to prepare two research teams, each consisting of six to eight members. Prior to the fieldwork, a thorough training will be conducted in Kathmandu, where all instruments will also be field tested before commencing the data collection work. This training will focus on human subjects' issues, interviewing techniques, observation techniques, recording of findings, etc. We envision the training to last eight days, which will also involve mock interviews with feedback, field-testing and pilot interviews in Kathmandu and surrounding areas, and modification of the discussion guides on the basis of feedback from the pilot interviews. Because the skills of the data collectors will be instrumental in the quality of the overall research findings, a great deal of emphasis will be placed on this overall training.

Both teams will first collect data from Rasuwa district in the form of a trial run. Rasuwa has been chosen because of its proximity to Kathmandu, which will also allow other members from our project to travel there to observe the first round of data collection. Both teams will be involved so that experiences can be shared and lessons learned can be applied in subsequent districts.

One team will then travel to Manang, finish data collection there, and then travel on to Bajhang. The other team will travel to Rupandehi, finish data collection there, and then travel on to Taplejung.

Method 1. Focus group discussions

The purpose of convening focus groups is to create a socially dynamic environment in which, through discussions, people are able to identify barriers to change and provide opinions and beliefs about key issues in their communities. Participants need to feel safe to express their opinions and beliefs freely, and a key challenge will be to ensure adequate participation from all members in the group.

- *Number & type*
 - 2 FGDs with mothers of infants younger than 1 year old
 - 1 FGD with fathers of infants and young children
 - 1 FGD with mothers-in-law
- *Recruitment.* Upon arrival in the designated community, the research team will introduce itself to community members and then elicit the permission and help of community leaders to conduct the study. They will then conduct an informal but comprehensive survey to determine the approximate number of homes, geographical dispersion, and ethnic and caste diversity in the community. They will also seek information about how many people falling in the three FGD categories (first-time mothers of infants younger than 1 year old; mothers of two or more young children; and fathers of infants and young children) reside in the community, creating a household listing of eligible participants. The team will also note whether

marginalized groups reside in the community, and if so, how many there are in the community and where they live. From the listing of eligible participants, eight people will be selected at random, and an additional two participants from the list of marginalized groups will also be randomly selected. Selected individuals will be asked to congregate in a location conducive to conducting a FGD – a venue that provides privacy and is conveniently located for most participants.

- *Administration.* The interviewer will first administer the informed consent form, seeking permission from participants to record the conversation. A digital recorder will be used for this purpose. A note-taker will also be present in the room.
- *Breaking the ice.* It is customary to start with some form of an ice-breaker. One technique often used to get the ball rolling is, literally, to roll a ball. In this exercise participants are asked a question (for example, what radio program they listened to that morning and why they either liked it or disliked it) and a ball is passed around. Whoever has the ball has to answer the question and then pass it on to another participant. This process is repeated until all participants have had a chance to talk.
- *Content.* FGDs begin with open-ended topics in which participants are encouraged to discuss issues of primary importance to them, their families, and their communities. The objective here is to create an open environment in which participants are free to initiate discussions about topics they consider important or problems they consider critical. The moderator will be trained to conduct the discussion in a “funnel”-like fashion – starting from a broad overview and then skillfully narrowing down the discussion until the required depth is obtained.
- *Techniques.* A number of creative techniques will be used to engage participants in discussions. These include:
 - *The Yes-But Game.* In this simple game, the facilitator invites participants to complete a sentence provided to them with the phrase “yes, but.....” For example, the facilitator might start with, “Always wash your hands,” and participants could then say, “Yes, but the water is dirtier than our hands.” The objective is to understand the barriers to change. Furthermore, these barriers can be subsequently classified into those at the structural level (“The well in the village has gone dry and no other source of water is available close by”), normative level (“None of my peers thinks it’s necessary to wash your hands each time”), or individual level (“I don’t see what difference it makes”). Outcomes from this effort will help the intervention understand and subsequently address the key barriers to change.
 - *Projective techniques.* Photographs and ambiguous drawings are shown to participants, who are then asked to provide the underlying story, to “fill in the blank” through their own narratives. Participants are asked, for example, “What is happening in this picture?” Or, “Why do you think she did that?” Or, “So what happened next?” The objective is to understand the larger cultural

narratives in a non-suggestive and non-judgmental manner. It is important to emphasize that there are no correct or incorrect answers, so that participants are able to express their opinions freely, without fear of being evaluated. Analysis of data from these projective techniques helps us understand individual-level motivations, interpersonal relationships, and socio-cultural norms that shape behaviors. These techniques can also paint a picture about the larger contexts in which behaviors are taking place.⁴

Method 2. In-depth interviews

While FGDs are useful for eliciting information through social interaction and discussion, in-depth interviews allow for knowledgeable individuals to provide key insights about people they serve (their clients, patients, etc.). Interviewers can probe deeply into topics about which interviewees have deep insights.

Two in-depth interviews with traditional healers: The objective here is to understand the perspective of someone whom partners turn to for medical advice. It will be important to know the factors that determine when or why parents turn to traditional healers (versus a medical or health clinic), including the type of health condition, characteristic of parents, and the social, community and environmental factors most closely associated with the use of traditional healers. It is also important to know what advice is provided by the healers for various conditions.

Two in-depth interviews with female community health volunteers and two in-depth interviews with health service providers. The objective here is to assess their knowledge and advise they provide about breast feeding (and duration for exclusive breastfeeding), feeding during and after diarrhea, and recognizing illness symptoms. Attempts will also be made to understand key barriers to providing high-quality services (from their perspective) and key barriers faced by their clients to accessing services (also from their perspective)

One in-depth interview with a model farmer and one in-depth interview with a local government official. The model farmer interview will seek to understand “positive deviance” behavior –the extent to which the person may have broken existing norms to innovate in farming style or methods. The government official will be interviewed to gain a better understanding about problems and challenges in implementing existing policies, to learn about where the bottlenecks are in the community or in policy, and to gain insights into methods for better implementation.

⁴ In a CCP-led study conducted in Mozambique, for example, people were shown a picture of a woman standing in front of a house, with a man in the background. When asked to weave a story about what the picture depicted, one group of participants said that the man in the picture, the woman’s husband (according to the participants), was upset and had just beaten her up because she had been rude to his parents when they came for a visit. This told us, among other things, that domestic violence was an issue that the project needed to consider. The project, on HIV prevention, would have completely missed this important context otherwise.

Recruitment. Traditional healers will be selected with assistance from community leaders, Female community health volunteers and health service providers will be identified on the basis of their experience working with a diverse group of clients and community leaders. Model Farmers will be identified after discussions with community leaders. Government officials will be identified on the basis of their employment in the local health office or ministry. Interviews will be done in a private setting, one-on-one with the interviewer, with another note-taker in the room.

Data Collection and Analysis

All FGDs and in-depth interviews will be recorded and the conversations will be transcribed verbatim. The transcription will then be translated. Data analysis will be done by members of the external research agency, with considerable input from the JHUCCP research team.

Method 3. Perceptual Mapping

Perceptual mapping is a technique used to elicit a mental picture held in common by members of a group. Perceptual mapping helps us understand how people construe various objects, both in terms of what meaning they give to them and how they construe the objects in relation to one another. Borrowed from marketing, this technique is increasingly used in social science research for formative evaluation. It uses multi-dimensional scaling in order to map the relative positions between objects (or persons, innovations, etc.) in people's consciousness. Perceptual mapping is done in three steps – attribute elicitation, scoring, and mapping.

- *Step 1: Attribute Elicitation.* The purpose of this step is to extract the meaningful attributes with which people construe specific objects. For example, if people are asked to list a significant attribute pertaining to “breastfeeding,” some may point to “shyness” as the primary attribute – that it conjures feelings of embarrassment, that it represents an act that cannot be done in public, etc. For others, breastfeeding may represent the idea of “wholesome” or “nutritious” as the primary attribute. Knowing these key attributes will help us craft meaningful messages. For example, we may be tempted to develop messages about breastfeeding on the assumption that it represents “nutrition” in the minds of participants. It may well be, however, that the primary attribute pertaining to breastfeeding for certain women may center around issues of modesty or barriers they face because of work demands. If this is the case, then our messages about nutrition would be far less effective than those that tackle breastfeeding from the perspective of modesty or work demands. This process of eliciting the underlying meaning given to objects, attitudes, and behaviors is often called a “functional approach”⁵; the idea is that the function being served by a behavior (breastfeeding) to the actor (mothers) must be the function invoked by a persuasive message. If, for example, the function being served by drinking Coke pertains to one's modernity aspirations, then messages that seek to reduce Coke consumption by emphasizing its cost or caloric content will not resonate with the audience.

⁵ Katz, D. (1960). The functional approach to the study of attitudes. *Public Opinion Quarterly*, 24, 163-204.

- *Step 2: Scoring.* A handful of attributes are thus identified for each primary behavior of interest. Respondents are then asked to rate the importance of each attribute for each behavior or object.
- *Step 3: Mapping.* Step 2 results in a p (number of attributes) \times q (number of behaviors or objects) matrix that is then used to model the relative distances between behaviors or objects on a p -dimensional plane, thus showing the relative distances among behaviors or objects. Two behaviors or objects close to each other on a particular attribute signify their conceptual proximity. This mapping provides an understanding about how the primary behaviors or objects of interest are understood by the audience; it also specifies the relative distances among objects.
- Three perceptual mapping exercises will be conducted: one among young mothers, one among young fathers, and one among grandmothers. Approximately 20 individuals per group will participate in the mapping exercise, for a total of 60 individuals per community.
- Recruitment for the conceptual mapping exercise will follow the same procedures as for the FGDs. These exercises, however, are done individually, not in groups.

Method 4. 72-hour participant observation techniques

- *Recipe analysis and cooking observations.* Recipes of key foods will be analyzed for the nutrition content and food preparation techniques will be observed over a 72-hour period.
- *Community observations.* Tabulations will be made of foods available in the community, including those sold in stores, grown in the fields, and stored at home. The objective here is to determine the range of foods available to residents.
- *Service point observations.* Observers will be provided with checklists to assess service delivery sites. These include assessing the quality of service, the inventory, waiting times, etc.

Timeline

| | |
|---|----------------------|
| 1. Finalize formative research design | December 15 |
| 2. First draft of RFP | December 20 |
| 3. RFP published..... | January 6 |
| 4. IRB submitted locally and in JHU | January 6 |
| 5. Deadline for submission of bids | January 23 |
| 6. Select agency through competitive review | January 30 |
| 7. IRB permission obtained..... | February 15 |
| 8. Contractual paperwork completed with agency..... | February 15 |
| 9. Training of agency staff conducted in Kathmandu..... | February 20 – Feb 28 |
| 10. Data collection begins in Rasuwa | March 1 – March 8 |
| 11. Review of procedures from Rasuwa and re-training..... | March 9 – March 11 |
| 12. Data collection in Manang (Team 1) & Rupandehi (Team 2) | March 14 – 20 |
| 13. Data translated and transcribed | April 1 |
| 14. Report, first draft | April 30 |
| 15. Report, final draft published | May 20 |

ANNEX A

Question Bank Used to Draw Questions for the Various Interviews and FGDs

Questions included in this section will be folded into the discussion guides and in-depth interview protocols. They are provided here to depict a range of options that will be considered.

Questions pertaining to dynamics within the household

At the household level, important questions can be raised with regard to the knowledge, beliefs, attitudes, and behaviors of parents and others who make decisions on behalf of infants and children. Prior research⁶ has found, for example, that while availability of foods is a key factor, one also needs to consider the food distribution practices within the home.

Prior research⁷ has also raised key questions in this domain that pertain to:

- Serving order in the home (when food is limited, who in the household is served first and who is served last?), cooking methods (whether certain foods are overcooked), and shared-plate eating practices (whether many children eat from the same plate, and if so, how distribution is determined)⁸
- Beliefs toward certain foods: which foods are considered to be “pure” and which ones as “contaminated” by certain groups
- Beliefs about the importance of exclusive breastfeeding and the role that mothers’ work cycle plays in early termination of exclusive breastfeeding
- Misattribution of nutrition-related problems among children to being stricken by external forces (*sato gayeko*) or being a complainer (*runche*)⁹
- Key behaviors, such as the extent to which the following occurs:³
 - Breastfeeding within the hour of birth and within the first 24 hours
 - Exclusive breastfeeding for the first six months
 - Complementary feeding
 - Prelacteal feeds
 - Duration and frequency of feeding
 - Foods consumed by mothers and they think they should eat during pregnancy and lactation including extra food
 - Vitamin A and iron consumption of children and mothers
 - Food hygiene
 - Utilization of services, including ANC visits
- Knowledge about different foods’ nutrition value has been found to differ widely by population,¹⁰ and hence it may not be appropriate to assume that knowledge about nutrition is already high

⁶ Gittelsohn, J. et al. (1991). Opening the box: Intra household food distribution in rural Nepal. *Social Science & Medicine*, 33, 1141-1154.

⁷ Adhikari, R. K. (2010). Food utilization practices, beliefs and taboos in Nepal: An overview. USAID.

⁸ Shankar, A. V. et al. (1998). Eating from a shared plate affects food consumption in Vitamin A deficient Nepali children. *The Journal of Nutrition*, 128, 1127-1133.

⁹ Adhikari, R. K., & Krantz, M. *Child nutrition and health* (2nd ed.). Kathmandu, Nepal.

- What is the level of self-efficacy that household members, but particularly pregnant and postpartum mothers, feel about their ability to provide adequate food, nutrition, and care for their infant and young children?
- What are prevailing beliefs and practices with regard to sanitation and hygiene, including hand washing?
- What are mothers' aspirations on behalf of their children, and what do they see as the key barriers to meeting those aspirations?
- How are decisions made in the home about caring for the child, and who plays a key role in those decisions?
- What should be the delivery structure and motivations for FCHVs and Poshan Aamaas to work as volunteers once they have been established.
- What would mothers like to do differently, if they could

Questions pertaining to factors external to the home

Outside the home, questions of interest to the project can be categorized in terms of those that pertain to the structural level, normative/cultural level, service delivery, and mass media.

Questions at the Structural Level

- What types of foods do people have access to on a day-to-day and seasonal basis? What barriers exist that prevent individuals from accessing nutritious foods?
- Are seeds of appropriate crops available to community members? Who does and doesn't have access seeds?
- What types of agricultural, health, and other services exist in the community? What is the cost (financial, transport, etc.) of accessing them? And, what is their quality?
- Are health facility staff members perceived to be helpful, friendly, and respectful of their clients? What barriers exist that prevent individuals from accessing health care?
- Do service providers have appropriate knowledge and skills to provide quality nutritional services
- What is the level of engagement of governmental agencies and community health workers with members of the community?
- Who are the gatekeepers and what nutritional role have they been playing within the community
- What are community needs in terms of water and sanitation, latrines
- What are the ' touch points within the community and service delivery system that encourage healthy nutrition practices
- What are the structural issues in the realm of health nutrition/food choices and breast feeding?
- What structures of opportunities are available or created for women and what can be built on existing ones?

¹⁰ Action against malnutrition through agriculture (AAMA Project). Formative research: Infant and young child feeding practices in Kailali district. Helen Keller International, Nepal.

- Are there individuals who have overcome these structural barriers? If so, who are they and how have they managed to overcome such barriers?

Questions at the Normative/Cultural Level

- What are the prevailing feeding practices for pregnant and postpartum women? What are the cultural norms around pregnancy and the postpartum period?
- What prevailing feeding practices put the lives of infants and young children at risk? This includes frequency of feeding, amount of food, texture of food, variety, active feeding and hygiene—including food handling.
- What gender norms prevent women from accessing services?
- What barriers are there to accessing micronutrient powders, Vitamin A and other products?
- What are the cultural norms surrounding breastfeeding, exclusive breastfeeding, and acceptable duration of exclusive breastfeeding?
- What is the level of engagement of household members (including those of husbands, mothers-in-law, sisters-in-law and others) in feeding, caretaking, and nurturing infants in the family? Are there examples of household members who are supportive of optimal feeding behaviors? What factors contribute to their support?
- What practices, beliefs, values, traditions at family and community levels constraint women, the poor and excluded from accessing to resources, opportunities and services?
- What are the different rules, practices, division of labour, social expectations, and differences in vulnerability for women and for different caste/ethnic groups? How have these impacted women, poor and the excluded and their food/nutrition behavior?
- What BCC Channels are most effective in reaching our target audience? What are the trusted sources of information which we can build on?
- Who are influential and key decision makers in deciding to seek care for ANC, postpartum/newborn care, immunization, sick child care (IMCI) and FP?
- What are views of mothers and community on under nutrition and what are the family and community level aspirations?
- How do socio-cultural factors influence decision making of women on health, nutrition/food behavior? (who makes the decision about women and children's health and around nutrition/food distribution and consumption)
- What are the intra-household norms and practices for food distribution and consumption?
- What are the norms and values that influence health, food/nutrition and breast feeding behaviors?
- How do women of different social group negotiate their health, nutrition/food choices?
- How are their behaviors controlled and regulated/monitored in a structurally constrained setting?
- What are the traditional role assigned to men and women and the practices of sharing the role among the members of the family (agriculture based role)?

- What are the key norms and practices that need to be changed around nutrition and hygiene and sanitation behavior? (What norms and practices themselves consider changing?)
- What are the socio-cultural barriers or underlying causes/factors influencing them for the adoption of learned behavior or to improve nutrition status and hygiene and sanitation behavior?